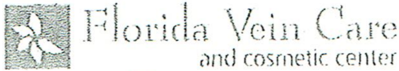

580 Rinehart Rd Suite 110 Lake Mary, Fl 32746
7009 Dr. Phillips Blvd. Suite 240 Orlando, FL 32819
10902 Dylan Loren Cir Orlando, Fl 32825
Florida Vein Care (407) 805-8989
Svelte (407) 804-5200
Fax (407) 805-8833

I, ______________________________
(Name of patient/guardian)

Date of Birth: ______________________

Social Security Number: ____________________

Give authorization for Richard S. Bragg, M.D. to:

__Release my medical records to:__Obtain my medical records from:__Discuss my medical records with:

Name: ____

Address: ____

Phone and Fax numbers: ____________________________________

THE SPACES BELOW GIVE SPECIAL AUTHORIZATION FOR THE RELEASE OF INFORMATION REGARDING ALCOHOLISM AND/OR DRUG ABUSE, MENTAL HEALTH/REHABILITATION, HIV (AIDS) TESTING, AND/OR TESTING FOR SEXUALLY TRANSMITTED DISEASES.

INITIAL EACH LINE THAT APPLIES

_____ Medical information regarding alcoholism and/or drug abuse (if applicable) may be released to the recipient noted above.

_____ Medical information regarding mental health/rehabilitation (if applicable) may be released to the recipient noted above.

_____ Medical information regarding HIV (AIDS) testing and/or testing for any sexually transmitted diseases (if applicable) may be released to the recipient noted above.

I understand this consent is revocable by me, in writing, at any time except after the action has taken place. I also understand that this consent will expire either ninety days after the date of signature or automatically when the records requested on this form have been mailed to the above facility.